



SDOH Screening & Referral Metric Guide for CCOs

Updated December 2023

SDOH Screening & Referral Metric FREQUENTLY ASKED QUESTIONS

Background

In 2015 Oregon started exploring the possibility of an incentive measure focused on social determinants of health (SDOH) by developing a clinic-level food insecurity screening measure, which was considered but not adopted by the Metrics & Scoring Committee (MSC). In 2018 the Oregon Health Policy Board identified recommendations for the next coordinated care organization (Coordinated Care Organization) contract or Coordinated Care Organization 2.0. Per direction from the Governor those recommendations included a specific focus on addressing SDOH and health equity.

In 2018, with support from community-based organizations, the measurement governing bodies — the Metrics & Scoring Committee (MSC) and the Health Plan Quality Metrics Committee (HPQMC) — revisited the idea of a broader, plan level SDOH measure that would include, but not be limited to, food insecurity. The MSC requested that the Oregon Health Authority develop a measure concept that includes social needs screening completion and reporting of data, and possibly referral data. In response to these requests and priorities, Oregon Health Authority started the process of developing a broader social needs screening measure concept in 2019 and convened a public work group in 2020 which led to a screening measure pilot program in 2021. The measure passed in 2022. CCOs began measure implementation in January of 2023. ⁱ

The purpose of this FAQ is to address questions related to SDOH Screening & Referral Metric must-pass elements and describe how CCOs might implement the measure. Additional guidance and technical assistance can be found on [OHA's SDOH Incentive Metric webpage](#). ⁱⁱ

This FAQ will be updated as additional questions are addressed. Please email questions to Metrics.Questions@odhsoha.oregon.gov.

Definitions

Social Determinants of Health (SDOH): The social, economic and environmental conditions in which people are born, grow, work, live and age, and are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities.

Social Determinants of Equity: Systemic or structural factors that shape the distribution of the social determinants of health in communities.

Health-Related Social Needs (HRSN): An individual's social and economic barriers to health, such as housing instability or food insecurity.

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Screening

1. **Will there be a process for CCOs to request that other forms/sources be added to the OHA approved list of SDOH screening tools?**

There will be an annual process whereby CCOs can submit proposed additional screening tools for review and approval. If you would like to submit an additional tool for approval, please email us at metrics.questions@odhsoha.oregon.gov. The deadline for submitting additional tools for approval for each calendar year is June 30th of the previous year.

See the [additional screening tools memo](#) for tools that were added to the approved list in March 2023, to bring the screening tools list into alignment with other national measures. Other additions will be considered by OHA in mid-2023.

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2. **Can clinics submit their "home grown" tools to OHA for approval directly or will the CCO need to collect tools and submit them to OHA?**

If clinics wish to submit "home grown" tools for approval, they can do so by submitting the tool to their CCO. The CCO will collect the tools and submit them to OHA. It is recommended that clinics consult their CCO for guidance on evidence-based and preferred tools within the CCO system.

To meet the measure requirements, CCOs and providers must use tools on the approved screening tool list. There will be an annual process by which CCOs will submit all collected tools that require review. For more information on currently approved screening tools see the [additional screening tools memo](#).

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3. **None of the tools listed as pediatric address all 3 required domains. How should we handle that?**

Approved tools are no longer separated by adult and pediatric to prevent potential confusion and over screening within the same household. The screening tools should be used for the population the tool was developed. For example, the Accountable Community Health (ACH) tool can be given to a child's caretaker. For more information on currently approved screening tools see the [additional screening tools memo](#).

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4. **(Updated 12/8/23) For pediatrics, there are not any approved screening tool questions about transportation. Do we have to ask pediatrics about this domain? Of the two approved pediatric screening tools that include questions about food and housing, the pediatric population may not be able to understand the forms. Are there other options for screening pediatric patients for social needs?**

In order to be counted for the metric, members must be screened for food, housing, and transportation, including pediatric members.

These screening tools are intended for and will be understandable to the caregiver of the child, which counts as screening the child. For example, the Accountable Health Communities (AHC) can be given to caregivers. Please see page 6 of the [Guide for Using the AHC Social Needs Screening Tool](#) for examples of screening tool locations.

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5. (Updated 12/8/23) What is the minimum age to be counted in the eligible population for this metric?

There is no minimum age to be counted for Component 1 or Component 2 reporting of the metric. All ages are eligible, and adequate food and housing resources are very important for infants and toddlers.

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6. If CCOs pick a screener that has questions on topics other than housing, food, and transportation, are they required to ask the other questions as well?

As part of the metric requirements, CCOs are not required to ask questions on topics other than food, housing, and transportation, however, CCOs or their network providers may choose to screen members for other needs appropriate to the individual or population.

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7. Some clinics have made tweaks to questions from approved tools to make them more accessible to patients (e.g., improve literacy, cultural acceptability.) Is that okay and does OHA need to approve those questions?

If the clinic has the screening tool translated into a language not already available, OHA does not need to approve the translation of the tool. Please be aware many of the tools already have translations available, and CCOs should use these translations. With the exception of translations, adjustments to the screening tool would need to go through the annual screening tool approval process. If you would like to submit a tool for approval, please see the [additional screening tools memo](#) and email us at metrics.questions@odhsoha.oregon.gov. The deadline for submitting additional tools for approval for each calendar year is June 30th of the previous year.

OHA strongly encourages clinics to use the screening tools as written and will make limited approvals for screening tool adjustments. OHA recommends CCOs and providers to reach out directly to the authors of approved screening tools with feedback on tool language.

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8. There are a variety of different screening tools, approaches, and requirements of OHA programs. How can the CCO simplify so that members are not over-screened? How can we ensure providers are appropriately screening for each of these programs and not passing a limited dataset to obtain services in the easiest way possible?

CCOs can use the measure specifications, particularly the systematic assessment of screening (must-pass element 3), to identify what tools are used in what settings between now and December attestation deadline.

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9. Can singular questions be used from a screening tool, or must the entire approved tool be used to meet metric requirements?

The approved screening tool list contains screening tool names and the domain or domains for which the tool can be used. To satisfy the metric requirement that CCO members must be screened in all three domains (housing, food, and transportation) once a year, CCOs must use all questions from the OHA-approved tool and domain that the CCO has identified for use in the tool. For example, if a CCO chooses to use *Your Current Life Situation's* Food Insecurity questions, the CCO must ask all food insecurity questions in the tool. The CCO does not have to use questions from the tool that are not specific to the identified domain. Different tools may be combined to meet all three domain requirements. If a tool covers all three domains, OHA strongly encourages the CCO to use only that tool and not mix and match domains from other tools.

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10. A few clinics are implementing a visual pre-screener which would be entered into the EHR as yes/no responses. Clinics are implementing this to save time on screening all patients as well as addressing patient barriers to screening such as literacy. If a patient has a need, they are referred to a CHW and the CHW implements the full PRAPARE screener and then supports the patient with navigation and referrals. Is it necessary for these clinics to separate out housing, food, and transportation from this visual screener and ask approved screening questions for those 3 domains?

If the visual screener is not on the approved list, the workflow would not meet the measure specifications for component 2. This component measures the percentage of CCO members screened and, as appropriate, referred for services for three domains: 1) housing insecurity, 2) food insecurity, and 3) transportation needs. To qualify, patients need to receive an approved screening tool for all three domains (housing, food, and transportation). For more information on currently approved screening tools see the [additional screening tools memo](#).

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11. If re-screening is happening based on an identified need, does the whole screening tool need to be used again?

If screening occurs more than once in a year, the content and completeness of the additional screening is up to the discretion of the clinician, health care provider, and/or member.

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12. Regarding Must Pass Element 3, do CCOs have to survey their entire network of providers or just provider offices for the systematic assessment of screening? Also, providers include hospitals, pharmacies, Durable Medical Equipment (DME) providers, etc. that are unlikely to be screened. Is it necessary to survey them?

CCOs are required to systematically assess current screening by provider organizations. The intent of this requirement is to assist CCOs in developing a plan to fill screening gaps and limit over-screening. Since the measure requires every member to be screened, regardless of whether they receive health care services in any given year, CCOs must survey provider organizations in the Delivery System Network (DSN) and community organizations. This will allow CCOs to develop a comprehensive screening plan. OHA would anticipate that hospitals and pharmacies are potential screening partners.

Provider organizations that do not have direct patient contact do not have to be included in the survey. In addition, provider organizations that currently do not screen and are not anticipated to screen members, such as durable medical providers, do not have to be included in the Element 3, 6 or 11 survey/environmental scan. OHA would anticipate that hospitals and pharmacies are potential screening partners, especially in rural areas, and should be included in the survey. OHA has not required or mandated that hospitals or other entities do social needs screening.

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13. If a CCO makes a good faith effort to collect information from all organizations in their Delivery System Network (DSN) and all contracted CBOs and social service agencies, but some organizations do not complete the survey, are requirements for must-pass elements 3 and 6 still fulfilled?

Yes, CCOs are expected to make a good faith effort to collect the needed information to understand the capacity within their network and service area. If CCO partners do not respond to a survey, this non-response may be recorded and reported as such.

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14. (Updated 12/8/23) Are CCOs expected to reach out to every single provider organization in their DSN report to assess social needs screening practices, including providers who are located outside of the CCOs service area? In cases where providers outside of the CCO are already being surveyed by other CCOs, how can we reduce duplicating efforts and over-surveying provider organizations that may be contracted with multiple CCOs?

CCOs are expected to make a good faith effort to connect with all provider organizations in their DSN to conduct the environmental scan and screening survey. See screening question 10 in the FAQ.

In order to reduce duplicate efforts and over-surveying of provider organizations, collaboration is encouraged among CCOs who share service areas or have adjacent service areas. OHA encourages CCOs to connect to share surveying tools, approaches, and data when conducting these provider organization surveys.

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15. Will providers be paid for screening patients for social needs? Typically, Z codes are not billable. What guidance does the state have for billing?

There are codes in the measure specifications that are billable. Under the CCO model, CCOs enter into payment arrangements with providers. OHA is not typically responsible for paying for services needed to meet incentive measures. As HRSN benefits begin, there may be a payment structure for some screenings. Some, but not all, Z codes are billable. If a CCO anticipates needing specific Z codes, OHA can determine if the codes are allowable. CCOs should contact their OHA Account Representation to connect with the appropriate OHA subject matter expert for billing consultation.

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16. Will there be any billing codes added for Community Health Workers (CHWs) to complete this work?

There are approved Fee-for-Service billing codes for CHW services that are explained in the [CHW billing guide](#). Helping members navigate community support systems is included in selected covered services. CCOs can consult with OHA if they have additional CHW codes they would like to use. CCOs should contact their OHA Account Representative to connect with the appropriate OHA subject matter expert for CHW billing code consultation.

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17. (Updated 9/19/23) To meet must pass element 1, should a CCO incorporate member voice in the policies and processes established by CCOs must-pass elements 2, 5, 8, and 10 as well as data sharing and data collection processes?

Yes, member voices should be incorporated into all policies and procedures related to screening, referrals, and sharing members' information and data – including must-pass elements 2, 5, 8, and 10 regarding screener training, over-screening policy, referral protocols, and the use of REALD data to inform screening and referrals. Sharing policies with your Community Advisory Council (CAC), gathering feedback, and incorporating their input into the policies is one appropriate way to include member voice across all of these policies. Must pass element 1 also requires that member input is gathered on the sharing of member's information and data to improve care and services.

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18. (Updated 9/19/23) Regarding meeting must-pass element 3, what are examples of social services OHA would suggest being in contact with?

Must-pass element 3 requires a CCO to conduct a systematic assessment of screenings done by a variety of entities including CBOs, social service agencies and/or other SDOH partners with whom CCOs have *current* agreements in place. Social services may include those offered by governmental, tribal and/or private organizations, including community-based organizations. The types of social services may include services that support members to meet their needs related to housing, food, or transportation.

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19. (Updated 12/8/23) What is the CCOs role in tracking screening and referrals, especially in the case of small clinics that do not have the capacity for tracking this? What aspects of this new social needs screening metric implementation fall to the CCO and what aspects fall to partners?

CCOs are responsible for metric implementation. The denominator for Component 2 Rate 1 is the percentage of CCO members from the OHA-identified sample who were screened for each of the three required domains at least once during the measurement year. The denominator is CCO members who are continuously enrolled for 180 days or more in the measurement year. “The SDOH work group members felt a significant strength of the proposed measure concept (over others the work group considered) is that it would incentivize screening of all CCO members, which promotes equity and ensures no members with social needs are missed.”ⁱ

The screening and referral does not have to happen at the clinic level since it is full population and not a visit based measure. Screening and referral strategies beyond clinic settings can involve a variety of initiatives. These may include collaboration with community partner agencies for on-site screenings, employing health risk assessments, distributing screening tools via mail, conducting screenings over the phone, and implementing text-based screening approaches. To ensure coordination, it is recommended that CCOs develop policies, training, and data sharing systems that are responsive to clinical provider capacity and needs. For data sharing and tracking, CCOs should set up systems that allow them to collect information on the member and communicate across providers and community partners.

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20. Which clinic staff are eligible to give the screenings? Will this screening be able to engage with THW’s workforce?

The measure specifications do not require specific staff to administer screening. OHA encourages CCOs to provide adequate training for screeners regardless of their role in the clinical delivery system. The traditional healthcare workforce is particularly well suited for screening for health-related social needs given their training and expertise.

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21. (Updated 12/8/23) If CCO staff are not conducting screening what is the expectation for staff to be trained?

Must pass element 4 requires CCOs to review the training policies of its partners and, if needed, provide training resources to partners. CCOs need to ensure that training is adequate and meets the requirements of the CCO screening training policy in line with element 2 to establish written policies on training. After the review of the partners training policies, the CCO should adjust its own training policies for assessing members' unmet social needs annually.

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22. (Updated 12/8/23) Can CCOs use the Health Risk Assessment referred to in Care Coordination rules to screen members for social needs for Component 2?

For Component 2, if the questions in the Health Risk Assessment are questions from the OHA approved screening tool list or the organization has received an exemption for the tool for a given metric domain, the Health Risk Assessment can be used to screen members for that domain. Please note that Rate 1 requires that members be screened in all three domains (food, housing, and transportation).

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23. (Updated 12/8/23) Can CCOs use the same screening questions they are using for the measure with the 1115 waiver transitions populations?

For the metric, CCOs are asked to use or ensure that their network providers use a screening tool from the OHA- approved list. Please refer to the [OHA Transformation Center Webpage](#) for the list of OHA-approved screening tools. These approved screening tools ask information about a person's social needs that can help CCOs or service providers identify someone who may be eligible for the HRSN benefit. The information collected from the OHA approved screening tools for the metric may include some of the required information/data needs for the HRSN benefit, but a CCO will likely need additional information to determine service eligibility for the HRSN benefit. Please see [OAR 410—120-2000](#) for more information on information/data needs related to the HRSN benefit.

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Referral Practices & Resources

1. If a CCO has existing contracts with community-based housing, food, and transportation vendors (e.g., for SHARE investments) can those also count toward this metric?

Yes, if these contracts:

Are in place as of December 31st of the measurement year; and

The scope of work outlined in the contract or agreement aligns with the metric requirements.

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2. Regarding must-pass element 12 (enter into agreement with at least one Community Based Organization (CBO) that provides services in each of the 3 domains) for Measure Year 2023, can current CBO partners work for meeting this metric element? Or does it have to be new partners?

Existing partners that you currently have may be able to meet this element, but it depends on what types of services those partners are providing and if their services support the three health-related social needs domains (housing, transportation, and/or food) of this metric.

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3. What should be included in written agreements with CBOs to meet the SDOH Screening and Referral Metric requirements?

To meet must-pass element 12 for the SDOH Screening and Referral Measure, CCOs must have a written agreement with at least one CBO, social service agency, or other social determinants of health and equity partner for addressing food insecurity, housing insecurity, and non-medical transportation services by the end of Measure Year 2023.

OHA does not prescribe what CCOs have in contracts, but recommends that contracts include specific services members will receive, payment arrangements, billing arrangements, any approval processes that may be required around referral, and provision of services. These contracts should be centered on delivering services in the three domains to members.

It is also recommended that CCOs establish contracts with vendors who will administer screening on behalf of the CCO. These contracts should include payment arrangements, billing arrangements, and any approval processes that may be required around referral. These contracts should include a scope of work that includes how often a member is screened, how to get approval for the service, and payment provisions.

Lastly, it is recommended that contracts with providers are put in place around social needs screening. This is in part to reward providers for doing the screenings, but primarily to outline payment for social needs services.

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4. Is there mechanism by which CBOs can be paid for providing, housing, food, and non-medical transportation services?

The metric specifications require CCOs to have contracts with CBOs to support identified housing, food, and transportation needs of members identified through the measure. Depending on the specific services or programs being offered by the CBO, payment for provision of services could be supported via one of the CCO spending programs:

Health Related Services (HRS); or
Supporting Health through REinvestment (SHARE)

CCOs are also encouraged to pursue value-based payment arrangements with CBOs when relevant. As the 1115 Medicaid Waiver Health Related Social Needs (HRSN) benefit is implemented, this will also become a potential pathway for CBOs to be paid for covered services.

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5. *(Updated 12/8/23)* What is the role of value-based payments in the context of the metric?

The metric does not include any must pass elements related to payment or reimbursement for screening, referral or provision of social needs services. OHA recognizes that CCOs need to pay or reimburse partners for these types of services for social needs screening, referral and/or provision of services, and that value-

based payment arrangements are one way a CCO may choose to support partners to perform these activities. If you have interest in learning more about value-based payment in relation to this metric, please contact Summer Boslaugh at SUMMER.H.BOSLAUGH@oha.oregon.gov.

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6. North Carolina developed a fee waiver - are we collaborating with them?

OHA is reviewing documentation and lessons learned from North Carolina's 1115 waiver demonstration.

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7. (Updated 9/19/23) How will 1115 Waiver language be supportive and not restrictive of what is required of the metric?

The SDOH quality incentive metric asks CCOs to screen and refer ALL CCO members while the 1115 Medicaid waiver HRSN benefit will serve specific transition populations. Therefore, the SDOH quality incentive metric work is broader. The three health-related social needs defined in the waiver are housing, nutrition and climate while the SDOH quality incentive metric social needs domains are housing, food/nutrition, and transportation. OHA is working across different divisions to align and integrate the various policy and program efforts that support Medicaid members social needs, including both the SDOH quality incentive metric and the HRSN benefit. For updated information about the 1115 Medicaid waiver visit this website: <https://www.oregon.gov/oha/hsd/medicaid-policy/pages/waiver-renewal.aspx>

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8. (Updated 9/19/23) For the purpose of must-pass element 12, what are the definitions of community-based organization, social service agency and "other social determinants of health and equity partner"?

Related to the SDOH incentive metric and must-pass element 12, a community-based organization, a social service agency and/or other social determinants of health and equity partners are entities with whom a CCO would enter into a formal agreement to provide services in each of the three domains as outlined in the specifications. OHA does not specify the business type of these entities. Any entity with whom a CCO establishes a formal agreement must be qualified to provide the services outlined in an agreement as determined by the CCO establishing the agreement.

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9. (Updated 12/8/23) Does an agreement with a medical transportation provider that includes providing transportation for housing and food related needs fulfill the requirements around must-pass element 12 for transportation services?

OHA recognizes that there may be a gap in community partners who can provide certain social services, including transportation services, and that this may be particularly the case in rural areas. As part of the metric must pass element 12, a CCO may choose to enter into a partner agreement with a medical transportation provider for the purpose of providing social needs related transportation as long as the agreement and/or contract delineates the scope of work and budget for the different types of transportation supports provided including:

medical transportation;
non-emergency medical transportation (NEMT); and
transportation to support social needs like food and housing.

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Data Collection & Sharing

10. How would a CCO be expected to standardize the ways that data is reported to them? We understand that there are approved screening tools, but those tools do not report the same data elements in the same manner, so how would a CCO be expected to format that data as it is ingested from varied sources?

OHA will provide a standardized reporting template for Component 2 data collection. Individual survey responses from the list of approved screening tools are not required to be collected and submitted to OHA. However, CCOs may choose to collect this data to improve member services and referrals.

CCOs will be responsible for indicating whether an individual screened was positive or negative for each of the three domains: housing insecurity, food insecurity, and transportation. Administrators of the questionnaire should follow the tools guidance on what qualifies as a positive or negative finding. Beyond the data elements that will be required in the Component 2 reporting templates, CCOs should standardize data according to their internal needs. OHA is currently examining similar national metrics to align the reporting template and will be providing a draft Component 2 reporting template for public comment later this year.

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11. Regarding approved screening tools, many of the approved tools are laid out in such a way that they could be delivered to a member electronically for completion or filled out on paper during intake at a clinic, and then followed up on when they are reviewed by staff. However, much of the language in the measure also refers to the need for empathy and trauma-informed care when doing screenings. To count for the measure, do screenings have to be wholly delivered verbally by staff? Or can they be completed by the member and then reviewed afterward? If so, will there be a timeline or threshold associated with this follow up for the encounter to count for the measure?

- The approved screening tool should follow the data collection protocol outlined in the chosen tool's instructions.
- No timeline for when the referral is made is currently listed in the technical specifications. As part of the work on Component 1 of the metric, CCOs should set up policies to ensure timely referrals are made.
- Thresholds, or scoring algorithms, listed in the approved screening tool for housing, food insecurity and transportation needs should be used to determine who qualifies for a referral for each type of social need.

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12. How can CCOs and clinics coordinate and work together to identify and screen patients who have not been seen in the clinical setting in the measurement year?

The scientific evidence on screening suggests that patients prefer to be screened by people with whom they have a trusted relationship. For those members not seen in clinical settings in a measurement year, CCOs and clinics can work together to identify where there is a trusted relationship and delegate outreach to that member for screening accordingly.

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13. As OHA will be providing the list of members for this sample data collection, how will OHA be defining the member cohort?

At this time, OHA anticipates that the member cohort will be a random sample of 411 members from each CCO.

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14. When it comes to SDOH data sharing, we have been working with HIPAA, but CBOs may not have familiarity with HIPAA protocols or PHI privacy requirements. Is there any guidance especially for CBOs or when working with CBOs regarding data sharing?

CCOs should obtain their own legal advice about data sharing with CBO partners to determine and maintain compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Protected Health Information (PHI) privacy requirements.

To determine whether and how a CCO can share member data with a CBO partner, the CCO must determine:

- The type of relationship they have with the CBO (business associate, HIPAA covered entity or neither)
- The purpose of information/data sharing (treatment, payment, health care operations or other purpose)
- If member/patient consent is needed to share information, CBOs would also benefit from consulting with an attorney about data sharing. CBOs may be HIPAA covered entities, business associates of a HIPAA covered entity, or neither. This should be determined by each CBO in consultation with the applicable CCO and legal counsel for both considering the type of services they provide and the data/information that is shared. HIPAA covered entities are health care providers, health insurers, and health care clearing houses. Business associates are entities doing something “on behalf of” the covered entity.

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15. What will reporting for the metric look like? Will OHA provide a survey for CCOs to attest to each of the structural requirements, or will OHA be requiring CCOs to submit actual data (e.g., of tools used, contracts with CCOs, etc.)?

The must pass elements in year one will be documented through CCO attestation of completion. OHA will collect the self-attestation report through an online survey tool. A pdf of the survey attestation form is in development and will be available and posted on the CCO Incentive Metrics website. The self-attestation will require CCOs to answer yes or no to achieving each must pass element by December 31st of the measurement year. Submitting supporting documentation is optional.

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16. What are “other qualified data sources” as this applies to the measure? Will CCO’s be able to request that a data source be approved by OHA? What would that request for approval look like?

CCOs are encouraged to use Community Information Exchanges (CIEs) and/or Electronic Health Records (EHRs) to facilitate the sharing of SDOH screening and referrals across medical, dental, and mental health providers, Community Based Organizations (CBOs) and other partners who can meet members' social needs. However, OHA is tool and data source agnostic as long as the tool meets relevant Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Protected Health Information (PHI) privacy requirements. The information tracked in the data source should align with component 1 and 2 and ensure social needs screening and referral are implemented in an equitable and trauma-informed manner. OHA plans to remove the "other qualified data sources" from the measurement specifications for Measurement Year (MY) 2024.

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17. Regarding there being no requirement to submit additional information with the metric attestation: What is OHA hoping for? Will it be a best practice to include extra information? How will OHA use the extra information included, if included?

Submission of supplemental materials is not related to passing or failing the metric, but rather would serve as a way for OHA and technical assistance providers to support CCOs and learn along the way as the systems change metric work is implemented.

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18. (Updated 12/8/23) When will the MY23 self-attestation form be released?

For informational purposes only, the [Final Measure Year 2023 Self-Attestation](#) is now available as a pdf. OHA has created [the Measure Year 2023 Self-Attestation form in SurveyMonkey](#). CCOs will be required to fill out and submit the form in SurveyMonkey. OHA will **not** accept an emailed pdf of the form.

The draft CCO Metrics Timeline & Due Dates through June 30, 2024 was available for public comment through December 12th. The proposed timeline is March 15, 2024 for submitting the Measure Year 2023

Self-Attestation form to OHA. The final CCO Metrics Timeline & Due Dates through June 30, 2024 will be posted by December 31, 2023.

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References

Definitions per OAR 410-141-3735: <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=285449>

ⁱ SDOH Measurement Workgroup Final Report:

<https://www.oregon.gov/oha/HPA/ANALYTICS/SDOH%20Page%20Documents/3.%20SDOH%20measurement%20work%20group%20final%20report.pdf>

ⁱⁱ OHA SDOH Incentive Measure Website: <https://www.oregon.gov/oha/hpa/dsi-tc/pages/sdoh-metric.aspx>